Responses to the Illinois Health Care Reform Implementation Council's
Request for Public Comment on Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois
From the Sargent Shriver National Center on Poverty Law
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The Council's proposed questions to consider on Functions of a Health Benefit Exchange and the Shriver Center's responses:

1. *What advantages will Illinois see in operating its own Exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?*

Shriver Center response: Illinois' participation in a federally run Exchange could be beneficial for our state. A federal Exchange can potentially create larger insurance markets and risk pools and lowered administrative costs by achieving economies of scale. This is especially true if there is a national Exchange available in all states lacking an ACA-compliant state equivalent. A federal Exchange would solve the issue of how to deal with markets that span state boundaries, such as where an individual may work in Illinois but live in another. Also, federal requirements may be stricter than those in place in Illinois' lax insurance regulatory environment.

However, a state-based Exchange could adapt to the special circumstances of Illinois. For example, by ranking insurance plans based on their handling of chronic diseases that are unusually prevalent in regions of Illinois. Having control at the state level could make the Exchange more responsive to Illinoisans' concerns. Additionally, an Illinois Exchange could better align benefits and providers for people who move between private insurance and Medicaid. On balance and at this time, the Shriver Center supports an Illinois Exchange.

2. *What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?*

Shriver Center response: The Exchange should offer private insurance market plans that are truly affordable and offer comprehensive coverage. The insurance industry should help promote and facilitate a private insurance market environment where individuals and families can easily purchase comprehensive coverage that satisfies the individual mandate. The Exchange should be focused on the best interests of individuals and small employers purchasing through the Exchange. The Exchange should offer an optimal combination of choice, value, quality and service. The Exchange should work with insurers that exhibit the desire to meet these policy goals.

Illinois needs its health insurance Exchange to be much more than a digital marketplace for conventional insurance products. Illinois needs its Exchange to be a health insurance marketplace that is smartly designed to drive health system improvement through competition that gives consumers a choice between high-performance coordinated care models based on the cost and quality of care they deliver. Indeed, Illinois should embrace the full potential provided by its Exchange to drive health care delivery toward higher standards of performance.

3. *What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?*

Shriver Center response: Illinois should undertake additional regulatory and market functions in order to improve the quality of services and make Illinois' Exchange a more attractive venue through which to access coverage. Illinois' Exchange should limit the number of health plans available on the Exchange, by allowing only the highest quality plans to be available through the Exchange after a competitive procurement process. Illinois' Exchange should negotiate with insurers over items such as benefits and premiums. Illinois' Exchange should reward the adoption of new tools (e.g., electronic health records, offering affordable, comprehensive coverage in the external market) in purchasing decisions.

Also, Illinois' Exchange should require additional reporting from insurers in order to provide consumers and the public with all necessary information to make a well-informed, accurate decision on coverage options. Illinois' Exchange should operate in a dynamic way by eliciting information from consumers covered through Exchange products in order to remove barriers and modify future purchasing decisions based on consumer needs and consumer feedback.

Additionally, Illinois' Exchange should have the capability to provide administrative functions on behalf of payers or small employers, such as collecting, aggregating and passing through premium payments, coordination of electronic health records for patients moving from one insurance plan to another, and a matching system for consumers that wish to continue receiving care from their existing primary care provider. Finally, the Exchange should consider using its regulatory power to promote the policy goal of comprehensive coverage for all Illinoisans by requiring that providers in Exchange plans also participate in Medicaid and CHIP.

4. *What advantages are presented to Illinois if the Exchange were to limit the number of plans offered? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?*

Shriver Center response: The Illinois Exchange must limit the number of plans offered so that plans are forced to compete on attributes such as price and quality rating. Illinois' Exchange should set very high certification standards and use its market share to drive down prices and drive up value. The Exchange should also require insurers to submit bids to participate in the Exchange, and limit participation to the plans that made the most attractive bids in terms of price, value, and other important variables.

Illinois must use the certification power of its Exchange to ensure that health plans meet the statutory requirements for qualification and that plans do not impose unreasonable premium increases on their members. This power should also be used to de-certify plans that fail these requirements or impose unreasonable premium increases. The Illinois Exchange should use its regulatory authority to lower prices and increase value to the extent that the competitive conditions in their markets allow. The Illinois Exchange should also standardize and limit the range of plan choices available within each tier to stimulate competition based on price and value.

The Council's proposed questions to consider on Structure and Governance and the Shriver Center's responses:

1. *If the Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?*

Shriver Center response: The Exchange should be located at an independent public entity, such as a quasi-governmental board or commission, or at an independent, non-profit entity. Whichever entity is selected, it must have the best chance of achieving transparency, accountability, and public participation, of avoiding partisan influence, corruption and patronage, and operating consistently over time and not changing policies with changes in administration. The governing entity must not interfere with or improperly inject bias into procurement processes. And a non-governmental entity that has no financial interest in the Exchange will have the highest likelihood of serving the best interests of consumers. This entity will need the expertise, authority, and sensitivity to work with insurers, third-party administrators, Internal Revenue Service, navigators, consumers, advocates, small businesses, HFS, DHS, and a variety of other stakeholders. The Exchange should maintain its independence from the Department of Insurance and HFS while also maintaining good working relationships with them.

2. *If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?*

Shriver Center response: The board should be independent and members should have significant demonstrated expertise in various Exchange-related health care areas such as Medicaid, and the individual and small group health insurance markets. Members of the board could include representatives of other state agencies with which the Exchange must interact, including Department of Insurance, HFS, and the consumer assistance or ombudsman program, advocates, and representatives of small businesses. Lower-income and minority communities and individuals with chronic diseases and disabilities should be represented.

There should be a strong conflict of interest provision that generally bars anyone working for insurers, agents or brokers, health care facilities and health care providers. An advisory board could represent insurer, producer, and provider interests while avoiding a conflict of interest. Enacting legislation or incorporating by reference existing state legislative provisions that would

prohibit Exchange managers or board members from moving directly to or from the insurance industry would also help avoid conflicts of interest. There should be one year revolving door provisions. The Board should meet in public session and provide an annual report on the fiscal impact of the Exchange on other state health programs and on implementation and expenditures. The Exchange board should be of manageable size (no more than 5-10 members). The members should be appointed by the Governor with the consent of the Senate and should serve for multiple terms. The members should be permitted to serve no more than two consecutive terms.

The Council's proposed questions to consider on the External Market and Addressing Adverse Selection and the Shriver Center's responses:

1. *Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?*

Shriver Center response: Illinois should maintain a dual market that successfully avoids adverse selection and promotes a strong and stable marketplace through its large, diverse risk pool. The Exchange should have as a top priority the promotion of enrollment in the Exchange. The dual marketplace is essential in order to provide comprehensive affordable private insurance plan options to those who are disallowed to purchase coverage on the Exchange, that is, certain non-citizens.

2. *What other mechanisms to mitigate "adverse selection" (i.e. requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?*

Shriver Center response: Illinois must include requirements for insurance sold in an external market to avoid adverse selection. We urge strongly support passage of state legislation that requires insurers that sell insurance outside the Exchange to comply with all of the requirements applicable to plans sold inside the Exchange. These requirements include guaranteed access to all plans; premium rates must be the same issue and outside of the Exchange; prohibition of rating based on health status; prohibition of pre-existing condition exclusions; prohibition of waiting periods longer than 90 days; and limitation on out-of-pocket costs. Illinois must require insurers to offer only the same plans in the external market as they do inside the Exchange. We urge strongly support passage of state legislation that requires insurers that sell insurance outside the Exchange to sell only qualified health plans. This is imperative for the Exchange to be a robust, vital marketplace.

Illinois must require insurers outside the Exchange to offer products in at least the Silver and Gold coverage levels, as they must do inside the Exchange. The ACA establishes the requirement to offer Silver and Gold plans only within the Exchange; applying that rule outside the Exchange as well will help to ensure more of a basic level of consistency in the products offered inside and outside the Exchange and reduce insurers' ability to offer only less comprehensive products — which attract healthier people — outside of the Exchange. Illinois

must ensure that the Exchange offers high-quality, low-premium plans. Illinois should pass state legislation that prohibits insurers that participate in the Exchange from establishing separate affiliates to sell only outside the Exchange.

Illinois should pass legislation that prohibits insurers from selling only bronze or catastrophic coverage outside the Exchange; and legislation that prohibits insurers from using marketing practices or benefit structures intended to attract healthy applicants to plans outside the Exchange while discouraging unhealthy applicants. The sale of catastrophic coverage must be restricted to plans that participate in the Exchange. Illinois must prohibit insurers from offering *only* Bronze plans or *only* catastrophic plans (as defined by the ACA) outside of the Exchange. Both of these types of plans will provide less comprehensive coverage than Silver and Gold plans and will cost less, are thus are likely to attract healthier people with lower health care costs. Illinois must not allow insurers to use catastrophic or Bronze plans to lure healthy people outside the Exchange, particularly if an insurer has no products within an Exchange and therefore would not be subject to the "single risk pool" requirement.

Illinois must require the same quality improvement and marketing requirements for plans offered in the Exchange and in the external market. The Exchange Board should develop additional criteria that may help to prevent adverse selection.

Moreover, grandfathered plans must be carefully monitored to make sure that they are not encouraging high-cost enrollees to move to the Exchange. Illinois should consider imposing on grandfathered plans requirements of the ACA that are only applied by the ACA to non-grandfathered plans. If Illinois does not impose these requirements on grandfathered plans, low-risk enrollees may face a strong temptation to keep their grandfathered plans while high-risk enrollees will opt for the Exchange.

We also recommend consideration of the creation of a public qualified health plan to bring additional competition into a market.

Lastly, Illinois should consider providing state and local government employee coverage through the Exchange in 2017, in order to greatly expand the size of the Exchange participant pool.

3. *Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?*

Shriver Center response: The Shriver Center would consider supporting any hybrid model that avoids adverse selection and ensures that there are low cost, comprehensive plans inside and outside the Exchange.

4. *If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?*

Shriver Center response: Illinois' health insurance Exchange will be "public face" for health reform and the centerpiece of the private insurance reforms. A well-designed and implemented Exchange can create sizeable and stable risk pools in Illinois, minimize adverse selection, wield bargaining power with insurers, and hold down administrative costs, all while providing greater choices to Illinois enrollees. The Exchange needs to be designed to ensure expanded coverage to the more than 1.65 million uninsured Illinoisans, improve the quality of coverage, and reduce insurance costs. The Department of Insurance must be given maximum rate review and other approval authority by the Illinois legislature to ensure that federal reform's promises are not empty ones and to make these changes real for our state's residents who have suffered from an unregulated state insurance marketplace for far too long.

Assuming that the Exchange and the external market operate in parallel, the same rules must apply to plans sold inside and outside an Exchange. This is imperative and the entire insurance marketplace will greatly suffer if this does not happen. Also, the same plans should be sold inside and outside the Exchange without exception. In this way, insurance companies will be unable to game the system to the detriment of consumers.

The Exchange needs to be tailored to Illinois and could include such features as interactive maps of coverage areas, or special rankings for the quality of treatment for prevalent chronic diseases in the regions of the state. The Exchange should educate consumers about their health—for example, how best to manage a chronic disease, or listing key prevention treatments.

The Exchange must certify plans for participation and must take excessive or unjustified premium increases into account in determining whether to make a health plan available through the Exchange. The policies of the Exchange must support an aggressive, consumer-focused regulatory role, by limiting participation to high-value plans. The Department of Insurance must have sufficient rate review and approval authority to sufficiently regulate insurers. Legislation should be passed and signed as quickly as possible to grant the Department review power so that it can adequately enforce the new provisions reform offers.

Effective September 23, 2010, plans can no longer discriminate against children with pre-existing conditions. In 2014, no one seeking coverage can be discriminated against because of a preexisting condition. While health reform ensures that most health plans will no longer be allowed to deny coverage or benefits to children with pre-existing conditions, insurance companies may attempt to use other tools to discourage these children from enrollment. For example, until 2014, federal law does not preclude them from charging significantly higher premiums to families because of the child's health status. Illinois should address this potential loophole by barring insurance plans from imposing excessive premium surcharges on families that have children with pre-existing conditions. Additionally, insurance companies may attempt to impose general plan waiting periods to dissuade enrollment. Illinois should ensure that state law prohibits insurers from imposing excessive wait periods (i.e., greater than 90 days) for coverage so that children do not face delays in accessing vital medical treatment.

5. *What rules (if any) should the State consider as part of establishing the open enrollment period?*

Shriver Center response: Illinois should allow appropriate exemption to any open enrollment periods, since it will take time for many families to learn about their new rights under the new law and to seek enrollment. Illinois should also consider setting rules under which the open enrollment periods operate, including restricting insurers' ability to underwrite outside of the open enrollment period, expanding when open enrollments must occur and how long they should last, and providing for special enrollment periods for families facing changing circumstances such as a job change.

In the event that Illinois allows large employers to opt into the Exchange, Illinois should permit the employer to switch to Exchange coverage only during an open-enrollment period. Illinois should also require plans that enter the Exchange to remain for a fixed period of time, or face a waiting period if they tried to return after leaving prematurely. Illinois should also consider having its Exchange impose a surcharge (carefully calibrated to avoid effectively barring large plans from the Exchange) on employers who do not enroll in the Exchange at their first opportunity to do so—that is, if the employer does not enroll when the Exchange is first available to employers of its size, or if the employer does not exist or does not offer health insurance at that point.

Individuals will enroll in the Exchange coverage like they would if they had employer-sponsored insurance with enrollment periods based on the calendar year and special enrollment allowed for changes in circumstances, such as birth of a child. If the verification process reveals an inconsistency involving citizenship or lawful status, HHS will notify the Exchange, which must handle it in the same way as citizenship inconsistencies are handled under Medicaid. That approach allows the Exchange to enroll an applicant for up to 90 days while additional documentation is requested, but must disenroll the applicant within 30 days thereafter if an inconsistency cannot be resolved.

If an inconsistency is found in financial information, the Exchange must make a reasonable effort to resolve it. If it cannot, it must notify the applicant and give the applicant at least 90 days to resolve the problem. During the 90-day period, the Exchange must determine eligibility on the basis of the information provided by the applicant, but if the inconsistency is not resolved by the end of the 90-day period, the Exchange must notify the applicant and eligibility must thereafter be determined based on the record. The 90-day interim enrollment period provides important protection for applicants.

6. *The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?*

Shriver Center response: Illinois' Department of Insurance or the Exchange will need to monitor to ensure that insurers are providing accurate information about the health status of their populations and that risk is actually being pooled across all of an insurer's plans as the law

requires. The Department of Insurance or the Exchange should conduct periodic audits of insurer data and close examinations of rate filings and other information that insurers provide to regulators, as well as rules to ensure that setting up an affiliate or subsidiary does not allow an insurer to avoid the "single risk pool" requirement. Illinois should encourage the U.S. Department of Health and Human Services to design a sophisticated but practical risk-adjustment system that states can use to discourage adverse selection against and within the Exchange among participating and nonparticipating insurers.

7. *Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?*

Shriver Center response If the Exchange is designed to make selection of plans easy for individuals and small businesses, then there is no need for brokers. As insurance plan enrollment moves increasingly online, one possible future scenario is that brokers and agents largely disappear from health insurance markets, just as online travel-booking services have largely replaced travel agents over the past two decades. However, if agents and brokers continue to have a role in the market outside the Exchange, they must also have a role on the inside; otherwise, they will shift business away from the Exchange or move high-cost business to the Exchange and low-cost business outside. Illinois' Exchange should limit brokerage commissions to a flat per member, per-month dollar amount. Also, agents and brokers should receive similar commissions regardless of the insurer whose policy they sell. And, they should face no incentive to steer enrollees to any particular insurer. Moreover, commissions should be the same for renewals as for new enrollments. Finally, agents and brokers should receive the same commission for sales both inside and outside the Exchange. In fact, Illinois should pass legislation prohibiting higher commissions outside the Exchange.

The Council's proposed questions to consider on the Structure of the Exchange Marketplace and the Shriver Center's responses:

1. *Should Illinois operate one Exchange or two separate exchanges for the individual and small group markets? Why?*

Shriver Center response: A strong and stable market relies on a large, diverse risk pool to reduce destabilization by large claims or a small number of high users. Therefore, Illinois should combine the two Exchanges into a single Exchange if, after careful analysis and input from all stakeholders, the State determines it is necessary to ensure a large enough to be stable and improve affordability. It is critical to adopt the structure that is attractive to a diverse population and ensures the greatest possible take-up in order to prevent the Exchange from becoming a "high-risk pool" substantially increasing its potential enrollment volume. While larger enrollment does not guarantee a risk pool for the Exchange that is well- balanced between the healthy and the sick, it does make it more likely. Greater enrollment promotes more robust competition among insurers within the Exchange. With a single Exchange, insurers would treat

their individual and small-group enrollees as one pool when setting their prices and offer them the same products.

Alternatively, Illinois may choose to wait on the decision to merge and focus on instituting ACA's major changes in the premium rating rules in both their individual and small group markets. These reforms may initially cause some substantial shifts in premiums, whether up or down, for individuals and small firms. Once the new rules are in place in both the individual and small group markets, however, it would likely be easier for Illinois to merge these markets. Because the new premium rating rules will be consistent across the individual and small-group markets and will have been in effect for several years, these markets could be merged within an Exchange at that time with less risk of market disruption. The Exchange Board could gather data for a period of time from the Exchange on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual market is maintained. The Board would then issue a report on whether or when to merge the individual and small employer market.

2. *If there will be separate markets and separate exchanges, how large must the pools within these markets be to ensure stable premiums for both?*

Shriver Center response: "See answer to question one."

3. *What should the Illinois definition of small employer be for initial Exchange participation in 2014?*

Shriver Center response: We have no position at this time.

4. *Should Illinois consider setting any conditions for employer participation in the shop Exchange (e.g. minimum percent of employees participating, minimum employer contribution)?*

Shriver Center response: We have no position at this time.

5. *Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?*

Shriver Center response: Illinois should permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016 if in doing so it promotes a strong and stable market and improves affordability. The addition of large group employers should only be permitted if it is attractive to a diverse population and ensures the greatest possible take-up while minimizing adverse selection.

If Illinois opens up its Exchange to large employers, the large groups that participate must purchase qualified health plans, i.e., the plans that they purchase for or make available to their employees must comply with all qualified health plan requirements, including the essential benefits requirements.

6. *Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?*

Shriver Center response: Illinois should not consider creation of a regional exchange. Illinois should only consider a multi-state Exchange if in doing so, they are better able to avoid adverse selection and increase the risk pools and purchasing power of an Exchange.

The Council's proposed questions to consider on Self-Sustaining Financing for the Exchange and the Shriver Center's responses:

1. *How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?*

Shriver Center's response: The state should consider whichever financing option has the least likelihood of adding to consumers' cost for coverage. This option might be charging assessments or user fees to participating health insurance providers (provided there is some safeguard that the fee is not passed on to consumers) or could be found in new targeted revenue proposals. The state should carefully consider all options and choose the option that encourages or at least does not discourages participation in the Exchange, that promotes transparency, and cost-effectiveness to consumers. However the Exchange is funded, it must be able to reduce the costs to insurers or to enrollees by at least enough to offset their own cost.

2. *What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?*

Shriver Center's response: Illinois needs a stable, consistent funding option.

3. *Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?*

Shriver Center's response: It is difficult to weigh in on the topic of the costs associated with state benefits mandates since the U.S. Department of Health and Human Services (HHS) has not yet defined "minimum credible coverage." Therefore, it is unclear to what extent, if any, Illinois' benefit mandates are included in that definition. At this junction, Illinois should assume that it should set aside funding to pay for the cost of those benefit mandates not included. It should be a separate financing mechanism than from the funding source for operating the Exchange. In the

event that all of the state's benefits mandates are included in the HHS definition, the state can move those funds into other areas of reform implementation.

The Council's proposed questions to consider on Eligibility Determination and the Shriver Center's responses:

1. *How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?*

Shriver Center response: The success of the Exchange will depend greatly on its ability to establish a streamlined enrollment and eligibility system that is seamlessly linked to the Medicaid programs. The Exchange should:

- Apply policies that will facilitate the development of a "no wrong door" enrollment system, including aligning, to the greatest extent possible, Medicaid rules and verification requirements;
- Create simple and efficient procedures for families to report "change of circumstances;"
- Build coordination between the delivery systems used by the Exchange and Medicaid, including offering the same benefit plans and creating overlapping provider networks; and
- Support the development of dynamic technology applications that will facilitate the connection between the Exchange and Medicaid programs and place less of a burden on families navigating in between.

Illinois should also make sure that if a consumer applies for Medicaid, but does not qualify, he or she is immediately connected to the Exchange and can access its subsidies. Whatever door a consumer enters through, they should quickly and easily receive the appropriate coverage. In fact, the Exchange is required to identify individuals who are eligible for Medicaid and ensure that they are enrolled without having to submit additional information or paperwork.

The Exchange and Medicaid should facilitate electronic applications that minimize the need for paper documentation. Interim assistance should be readily available in cases where eligibility cannot immediately be determined. The reconciliation requirements of ACA should be interpreted so as not to defeat the purpose of providing assistance to those who need it. Illinois' Exchange should have as its goal to ensure the continued enrollment of eligible individuals and families for tax credits or public programs, rather than holding individuals responsible for continually having to work at maintaining their own eligibility.

A large number of currently uninsured individuals who will become eligible for health subsidy programs under the ACA are already known to other public programs and supports such as the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), unemployment insurance, etc. In some instances, these individuals have authorized data sharing with Medicaid for purposes of outreach and enrollment, or the forms could be easily modified to obtain that consent. With such authorization, data and findings held by these other

programs could be used to identify eligible individuals and begin the eligibility and enrollment process along the lines taken by Louisiana in its Express Lane Eligibility (ELE) effort. The Exchange represents an unprecedented opportunity to inform visitors of their potential eligibility for other benefits or credits, such as SNAP, WIC, TANF, child care subsidies, or the Earned Income Tax Credit, and to simplify the process of applying and documenting eligibility for these income and work supports. The Exchange would be the most efficient portal for enrollment in these other programs. Illinois should take all steps possible to ensure that the systems being developed to promote access to health insurance can also be used to provide access to the full range of public income- and work-support programs.

Illinois should require portals to accept and export data in standard machine-readable formats so that information can be automatically transferred between health care portals and other state systems. This will also allow for third-parties to provide application assistance. The process for enrolling people into the Exchange must be developed in such a way that individuals can with a single application be routed to the subsidized program that best meets their needs without having to file a separate application. There must be a self-service, online process that allows people to provide basic information, have a real-time determination of eligibility (in most cases), and be able to provide individuals with navigation aids to help them make choices relevant to the category of coverage for which they are eligible (e.g. chose a private plan for those eligible, pick a Medicaid medical home if eligible for Medicaid, etc.). Certain tools, such as Internal Revenue Code matches, will be available to the Exchange to determine (and annually re-determine) income eligibility.

To minimize the burden of the renewal process on families and agencies, Medicaid/HFS should query other programs and/or verification systems for updated eligibility data to pre-populate a renewal form, which could then be mailed to the enrollee or made available online. It would be preferred if the enrollment system could automatically perform that data query and automate the renewal process at the end of an enrollment period, or when the individual renews eligibility for another public program and submits updated information. This ex parte, automated renewal process is currently being used by numerous state Medicaid programs.

Finally, applicants and beneficiaries must be given due process—that is, they must be informed of all decisions or eligibility, and allowed to appeal adverse decisions.

2. *When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?*

Shriver Center response: Illinois' Exchange will play an important role in administering subsidies to help low- and middle-income families afford insurance—an estimated 702,000 Illinoisans (Community Catalyst). The Council must ensure that the design and operation of the Exchange anticipates this vital role. The subsidy determination process should be joined with the Medicaid (e.g., FamilyCare, All Kids) eligibility-determination process, since families are likely to move frequently between Medicaid and the Exchange as their income rises and falls. In fact, the recent Census data shows that in 2009, nearly 7 million people lost coverage they

had previously obtained through an employer. And plans that participate both in Medicaid and in the Exchange market should be available, so that enrollees can move among programs without having to change plans. The Exchange should also help enforce the mandate to purchase insurance, by identifying individuals who are in compliance and by assisting those not in compliance but who wish to comply.

In addition, the Exchange must offer a range of plan options to the diverse Illinois population, while avoiding complexity. Specifically, the plans on the Exchange must be designed to consider the needs of vulnerable populations, especially those between 134% and 400% of the federal poverty level, many of whom have never previously accessed public benefits or were eligible for public health insurance. The Exchange must therefore offer affordable, comprehensive plans that are easily accessible and understandable. To ensure affordability of health insurance, Illinois' Exchange should negotiate premiums with insurers or, as a condition of being able to sell though the Exchange, require them to conform to premium limitations or other requirements. Lastly, the Exchange must offer convenient, fast, and responsive service to enrollees, which improves their experience in purchasing and dealing with insurers rather than frustrates or alienates them.

The Exchange must also successfully facilitate communication with the linguistic and cultural minorities of our diverse state. Lawfully-residing immigrants are allowed to purchase insurance on the Exchange and qualify for the subsidies. Almost one of every seven Illinoisans is an immigrant and our state is also home to more than 558,000 adults who do not speak English well. Illinois must ensure the policies, procedures and practices of the Exchange support rather than hinder these populations from being able to successfully navigate and purchase and access affordable insurance on the Exchange.

3. *What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?*

Shriver Center response: Low-income, low-wage individuals and families will experience a degree of movement between eligibility for Medicaid and for tax subsidies for private health insurance. Therefore, close coordination of the different categories of subsidized coverage is crucial.

The ACA allows states the option to provide medical homes to Medicaid beneficiaries with chronic conditions. Under this provision, a state can, as part of a state plan amendment, provide additional payments to a designated provider, team of health care professionals operating with a provider, or health team to treat eligible beneficiaries with chronic conditions. In Exchange, designated providers must provide regular reports to the state on a set of applicable quality measures. Illinois should continue to support the medical home system and apply for federal dollars under ACA. Delivery systems serving vulnerable populations should be anchored in primary and preventive care, which promote better quality and lower costs. Every Medicaid enrollee should have ready access to a primary care provider who is held accountable through

payment incentives for gauging the patient's needs and organizing and coordinating care across the full spectrum of services.

4. *Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?*

Shriver Center response: Through ACA, Illinois has the option of establishing a "Basic Health Program" for low-income individuals not eligible for Medicaid as long as their household incomes are less than 200 percent of the federal poverty level. It is our understanding that with this program, Illinois would contract directly with private plans to provide coverage and would receive 95% of the federal subsidies that would have been paid to individuals who receive premium credits for coverage in the new Exchange. Basic Health Plans must include at least the "essential health benefits" available through the Exchange. Illinois should explore this approach for low-income people under 200% of poverty level if it is determined to be more efficient and cost-effective than having these individuals purchase coverage through the new health insurance Exchange. The Basic Health Program has the potential to provide more seamless coverage for families that experience an increase in income that makes them ineligible for Medicaid while allowing them to remain enrolled in a similar form of publicly subsidized coverage with a similar benefits package. Illinois could also design this "Basic Health program" to allow parents and children to be covered under the same health plans--use the same plans in its Medicaid program and its "Basic Health program" so that a family could potentially enroll in "family coverage," or at least have coverage that includes the same provider network and/or cost sharing system for children (who are on Medicaid) and their parents (who are ineligible for Medicaid but meet the eligibility requirements for "Basic Health"). Such plans might well be easier for families to understand and use, which would thereby improve their access to health care.

Thank you for the opportunity to comment.

Sincerely,

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